

Kansas Medical Assistance Programs



Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

P.O. Box 3571, Topeka KS 66601-3571
Prior Authorization: 1-800-285-4978 or 785-274-5499
Prior Authorization Fax Lines: 1-800-913-2229 or 785-274-5956

Narcotic/Skeletal Muscle Relaxant Request Form

Consumer Name: _____
Consumer Medicaid ID #: _____ Date Of Birth: ____/____/____

Pharmacy Name: _____ Provider Medicaid ID#: _____
Phone Number: (____) _____ Fax Number: (____) _____

Date PA Requested: ____/____/____ Date of current dispenses: ____/____/____

Medication name and prescription instructions: _____
NDC #: _____ # of tablets/capsules being dispensed: _____
Date of last dispense: ____/____/____ # of tablets dispensed: _____
Is consumer in nursing facility? ____ Length of time on this medication: _____

Prescribing Physicians Name: _____ Provider Medicaid ID#: _____
Phone Number: (____) _____ Fax Number: (____) _____

Diagnosis for use of this medication (do not use codes):

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Prior authorization is not required unless the amount prescribed exceeds the maximum recommended dose. Please indicate medical necessity for exceeding dose:

—
Other treatments or medications tried and patients' therapeutic response:

—
All other medications patient is currently taking:

In order for prior authorization to be considered, the consumer must have all pain medication, including narcotics and muscle relaxants, prescribed by one physician and dispensed by one pharmacy.

Signature of Physician or Designee: _____ Date: ____/____/____

Pharmacy and prescribing physician's office should complete entire form and fax to 1-800-913-2229. This form will be returned unprocessed if it is not completed in its entirety.

If a case has been started and the information requested is not received within 15 working days, the case will be denied.